

NOV 3 1943 77  
Registration District No. \_\_\_\_\_

Primary Registration District No. 3016

Registrar's No. 216

1. PLACE OF DEATH:  
(a) County: Cole  
(b) City or town: Jefferson City  
(c) Name of hospital or institution: St. Marys  
(If not in hospital or institution, write street number and location)  
(d) Length of stay: In hospital or institution: 7 weeks  
(Specify whether years, months or days) 7 weeks.

2. USUAL RESIDENCE OF DECEASED:  
(a) State: Missouri (b) County: Pulaski  
(c) City or town: Dixon  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME: George Washington Shelton  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Oct day: 17 year: 1943 hour: 6 minute: 15 a.m.  
21. I hereby certify that I attended the deceased from Aug 15 to Oct 17 1943 that I last saw him alive on Oct 17 1943 and that death occurred on the date and hour stated above

4. Sex: Male 5. Color or race: Wh 6. (a) Single, widowed, married, divorced, widowed: Widowed  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

Immediate cause of death: Pneumonia Lobar  
Due to: Past operation  
Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

7. Birth date of deceased: August 13 1869  
(Month) (Day) (Year)  
8. AGE: Years: 74 Months: 2 Days: 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Major findings: Of operations: Prostatectomy  
Of autopsy: no  
PHYSICIAN: \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

9. Birthplace: Marion County Mo. (City, town, or county) (State or foreign country)

10. Usual occupation: Postmaster

11. Industry or business: U.S. Post Office

12. Name: Wylie S. Shelton

13. Birthplace: Unknown Mo. (City, town, or county) (State or foreign country)

14. Maiden name: Sarah B. Elma

15. Birthplace: Unknown Mo. (City, town, or county) (State or foreign country)

16. (a) Informant: G. C. Shelton

(b) Address: Columbia, Mo.

17. (a) Removal: (b) Date thereof: Oct 17 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Dixon, Mo.

18. (a) Signature of funeral director: James Sevier

(b) Address: 700 Jefferson

19. (a) 10-17-43 (b) Normal Richter  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
(Specify type of place) \_\_\_\_\_ (e) Means of injury: \_\_\_\_\_  
23. Signature: J. R. Aldridge (M. D. or other) \_\_\_\_\_  
Address: \_\_\_\_\_ Date signed: 10/17/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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STATE OF ARIZONA  
DEPARTMENT OF HEALTH  
DIVISION OF REGISTRATION

ARIZONA BOARD OF REGISTRATION FOR EMBALMERS

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed..... *S. Anderson*  
Licensed Embalmer No. *3641*  
P. O. Address..... *Pro*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34492  
Nov

State File No. \_\_\_\_\_

Registration District No. 77

Primary Registration District No. 3016

Registrar's No. 216

1. PLACE OF DEATH:

(a) County Cole  
(b) City or town Jefferson City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME George Washington Shelton

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Aug 13 1876  
(Month) (Day) (Year)

8. AGE: Years 74 Months 2 Days 3 If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) mo.

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER, FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_ Year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death Pneumonia Lobar

Due to \_\_\_\_\_  
Due to Past operation urinary obstruction  
Other conditions (include pregnancy within 3 months of death) Prostatectomy

Major findings: Of operations \_\_\_\_\_ Of autopsy 108

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature M.R. Aldridge (M. D. or other) \_\_\_\_\_  
Address Jefferson City, Mo. Date signed 11/24/43

SUPPLEMENTARY

WRITE PLAINLY - USE UNFADING INK FOR NAME AND TELEPHONE RECORDS

39492